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	175531	A. BUILDING _____ B. WING _____	04/22/2015

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ATCHISON SENIOR VILLAGE	1419 N 6TH ST ATCHISON, KS 66002

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 52 residents. The sample included 21 residents. Based on observation, record review and staff interview, the facility failed to investigate and report to the state survey agency for 2 of 3 residents sampled for abuse. (#46,60)

Findings included:

- Resident #46's significant change Minimum Data Set (MDS) dated 3/20/15 identified the resident scored 12 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS), required supervision for bed mobility, limited assistance for transfers, and extensive assist for toilet use, dressing, and personal hygiene.

The quarterly MDS dated 12/28/14 identified the resident scored 15 (cognitively intact) on the Brief Interview for Mental Status, and had an independent functional status.

The Mood State CAA dated 3/23/15 revealed the resident reported depression. He/she had Bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

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The revised care plan dated 4/15/15 revealed resident #46 hit a resident that hit him/her. Staff were to assist residents who tried to push other residents in wheelchairs, and redirect the resident.

The nurses notes dated 1/20/15 at 2:45 P.M. by licensed nursing staff K documented he/she spoke with the charge nurse and social services after the resident voiced concerns regarding another resident in the facility acted inappropriately. Staff did not observe inappropriate behavior by him/her.

The nurses notes dated 1/21/15 at 6:47 P.M. by licensed nursing staff I documented the resident indicated he/she felt discomfort with another resident when he/she passed by or stood near him/her. The resident stated the resident was fixed on him/her and was capable of "strange sexual" behaviors. No inappropriate behaviors were observed by the nurse.

The nurses note dated 2/26/15 at 4:43 P.M. by administrative nursing staff D documented resident # 46 pushed another resident in his/her wheelchair and swatted at resident #46. Resident #46 swatted the other resident back and was upset. The residents were separated and prior to meals, when other residents were headed toward the dining room, staff were to sit with the resident in the wheelchair.

A nurses note dated 3/4/15 at 11:03 P.M. by licensed nursing staff L documented the resident reported to the writer another resident poked him/her. Resident #46 responded by swatting the other residents hands. Staff separated the two residents from each other.

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A social services note provided by the facility dated 1/22/15 by administrative staff E documented the writer telephoned the residents guardian to inform him/her of resident #46 concerns with a male resident. The guardian stated the resident did this before in the past and sometimes his/her medications needed to be changed. The resident had a counseling meeting. Medication changes were not made at that time. Staff would watch the male residents encounters.

An observation on 4/15/15 at 12:33 P.M. resident #46 rested in bed with his/her sling on his/her arm.

An interview on 4/20/15 at 10:27 A.M. with resident #46 stated a resident with Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) was looking at me funny and staff stopped him/her.

An interview on 4/20/15 at 10:55 A.M. with direct care staff S stated the resident had exchanged hits with another resident and it was reported. The resident did claim unwitnessed things, he/she did not complain immediately when it happened so it was hard to be aware.

An interview on 4/16/15 at 4:40 P.M. direct care staff T stated he/she was aware the resident was uncomfortable with a certain resident.

An interview on 4/20/15 at 11:13 A.M. with licensed nursing staff J stated a resident hit resident #46 and resident #46 hit the other resident back. Staff J stated staff filled out incident reports and told the administrator and

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director of nursing, as well as complete and in-house investigation. He/she never knew about inappropriate behavior from other residents in relation to resident #46.

An interview on 4/20/15 with licensed nursing staff H stated a resident hit resident #46 one morning. Resident #46 pushed another residents in his/her wheelchair, his/her foot was dragging and he/she hit resident #46. Resident #46 slapped the resident and walked away. Staff H never heard of inappropriate behavior from another resident towards resident #46.

An interview on 4/20/15 at 3:53 P.M. with licensed nursing staff I stated the resident had a tendency toward paranoia and delusions that appeared to be centered around sexual attention toward him/her. Staff would chart issues observed, no other follow up was charted.

An interview on 4/16/15 at 4:31 P.M. with administrative staff E stated he/she asked the nurses to handle the follow up for residents. He/she would alert the nurse of resident issues and expected the nurse to follow up.

An interview on 4/20/15 at 9:58 A.M. with administrative nursing staff D stated he/she did not document talking with staff or follow up for resident #46 concerns about the resident who made him/her feel uncomfortable. Staff D revealed he/she talked to staff, but did not document it and had no other documentation to provide.

An interview on 4/20/15 at 12:51 P.M. with administrative nursing staff D stated the incidents on 2/26/15 and 3/4/15 were called into the state

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last week on 4/14/15.

An interview on 4/20/15 at 11:36 A.M. with administrative staff A stated staff sent the resident to a psychiatrist. Staff could not substantiate the 1/21/15 incident and had to check if investigations were done.

The Abuse, Neglect, Exploitation policy dated 2013 documented the director of nursing would investigate any verbal or written report of neglect, abuse, exploitation, or injury of unknown origin made by any resident, staff member, or family member. The facility investigation may take the form of physical assessment of the resident, medical record review, staff interview, collection of resident's statements and or other investigative techniques. Upon receipt of any report of abuse the director and/or administrator would initiate a documented investigation of the incident which should include the collection of signed statements, interview of witnesses, and and written evaluations and explanations of administrative action taken.

The facility failed to report two instances of resident to resident altercation as well as provide evidence of a full investigation for the mentioned incidences.

- Resident #16's (a closed record) admission Minimum Data Set (MDS) dated revealed the resident scored 9 (moderate impaired cognition) on the Brief Interview for Mental Status (BIMS) and had verbal and physical behaviors 4 to 6 days of the 7 day assessment period.

Resident #60's quarterly MDS dated 3/12/15 identified the resident scored 8 (moderate

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F 225	Continued From page 6 impaired cognition) on the BIMS and had no behaviors. A nurse's note dated 3/3/2015 and timed 11:10 P.M. documented a certified nursing staff reported that during supper time resident #16 asked staff members and students where his/her spouse was. The other resident was confused and did not know how to answer resident #16 and he/she punched the other resident in the face and the other resident grabbed resident #16 by the arm. Staff notified the resident's family, primary care physician and administrative staff D. A nurse's note dated 3/3/15 and 11:27 P.M. documented another resident punched resident #60 in the face and staff notified the resident's family, primary care physician and nursing administrative staff D. During interview with administrative staff A on 4/16/15 at 12:30 P.M. he/she stated he/she was aware of the allegation of resident to resident abuse between resident #60 and resident #16. He/she stated the facility did not report the allegation of resident to resident abuse to the State survey and licensing agency. The facility failed to report the allegation of resident to resident abuse to the State survey and licensing agency.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 52 residents. The sample included 21 residents. Based upon observation, record review and interview the facility failed to promote care in a manner that maintained and/or enhanced his/her dignity and respect in full recognition of his/her individuality for 1 (#36) of 3 residents sampled for abuse.

Findings included:

- Resident #36's quarterly Minimum Data Set (MDS) dated 3/8/15 identified the resident scored 14 on the Brief Interview for Mental Status (BIMS) had no behaviors, required extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, toilet use, supervision with personal hygiene and the activity of walking did not occur. The resident was always continent of urine.

The resident's care plan dated 3/5/15 included the resident wore underwear and told staff when he/she needed to use the bathroom by activating his/her call light or notified staff when he/she was in the hallway.

The resident's care plan did not address the resident repeatedly asked staff to assist him/her to the bathroom.

An investigation dated 4/10/15 included the resident reported he/she asked staff to assist him/her to the bathroom and staff told the resident he/she needed to wait until they finished playing cards. The report included the incident

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occurred 4/8/15 to 4/9/15 in the evening at approximately 7:00 P.M. to 8:00 P.M. Administrative staff A spoke with the charge nurse and was asked if anyone, even non-staff were playing cards and the charge nurse stated no. The charge nurse stated staff repeatedly took the resident to the restroom in the evening and the resident asked every 15 minutes or so to use the restroom.

On 4/14/2015 at 1:37 P.M. direct care staff P pushed a resident in his/her wheelchair and spoke around the corner to resident #36 and told the resident he/she had just taken him/her to bathroom. Direct care staff continued to push the resident down the hall talking about resident #36.

On 4/16/15 at 11:40 A.M. the resident sat next to the bathroom door and waited for staff to assist him/her to the bathroom. A direct care staff pushed another resident in front of him/her and entered the bathroom. A staff informed the direct care staff the resident wanted to use the bathroom. The direct care staff apologized to the resident and asked the resident if he/she could wait until he/she assisted the other resident. Staff assisted the resident to the bathroom at 11:55 A.M.

On 4/20/15 at 1:13 P.M. licensed nurse H stated the resident at times asked to use the bathroom up to 100 times in a shift. Licensed nurse H stated staff should assist the resident to the bathroom per request. He/she stated he/she had heard staff refuse to assist the resident to the bathroom and other staff informed the resident he/she had just assisted the resident to the

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F 241	Continued From page 9 bathroom and others have asked the resident to wait 10 to 15 minutes. Licensed nurse H stated the resident's care plan should address the resident's persistent bathroom request and how staff should address the issue. On 4/20/15 at 1:37 P.M. direct care staff O stated the resident sometimes requested to use the bathroom every 15 minutes, 20 minutes, every hour or every 2 hours. He/she stated a lot of time the resident did not remember staff had just taken him/her to the bathroom. On 4/20/15 at 4:27 P.M. licensed nurse M stated the resident consistently asked to use the bathroom and staff should toilet the resident per request. On 4/20/15 at 4:20 P.M. nursing administrative staff D stated at times the resident repeatedly ask to use the restroom and staff should take the resident per request. The facility's undated Dignity Policy and Procedure included all residents of the facility were treated with the utmost respect and dignity. The facility failed to treat this resident in a manner that enhanced and maintained his/her dignity.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 52 residents. The sample included 21 residents. Based upon observation, record review and interview the facility failed to act upon grievances expressed by the resident council.

Findings included:

- On 4/16/15 at 9:05 A.M. a resident on the 200 hall activated his/her call light. Further observation revealed staff did not respond to the resident's call light until 9:16 A.M. (a duration of 11 minutes).

Review of the resident's council meeting minutes from 2/14 to 3/3/15 revealed the following:

04/08/14: Residents expressed concern regarding long call light respond time

07/08/14: Residents expressed concern regarding long call light response time

08/05/14: Residents expressed concern regarding long call light response time

An undated meeting minutes: Residents expressed concern regarding call light response time

03/03/15: Residents expressed concern regarding call light response time

The minutes did not include resolution regarding call light response time.

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F 244	Continued From page 11 On 4/20/15 at 10:05 A.M. an alert and oriented resident stated he/she attended the resident council meetings. He/she stated resident had expressed concerns regarding long call light response time during the meetings and staff did not inform the resident council members of resolutions to concerns expressed during resident council meeting. On 4/20/15 at 11:10 A.M. activity staff ZZ stated he/she conducted the last 2 resident council meetings and residents expressed concerns regarding call light response times. Activity staff stated he/she provided a copy of the minutes to administrative staff A and nursing administrative staff D. On 4/20/15 at 11:15 A.M. administrative staff A stated there were 2 residents who consistently expressed concerns regarding call light response time. Administrative staff A stated he/she spoke with those 2 residents but confirmed there was no written evidence to support the facility acted upon the resident council grievance/concern regarding long call light response time. The facility's undated Grievance Policy and Procedure included the administrator and Director of Nursing came to a consensus regarding a resolution to the complainant and notified the complainant as to the decision. The facility failed to act upon the resident council grievance regarding call lights.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		

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A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 52 residents. The sample included 21 residents. Based upon observation, record review and interview the facility failed to ensure 1 of 3 sampled residents went to bed per his/her preference. (#5)

Findings included:

- Resident #5's Significant Change Minimum Data Set (MDS) dated 4/1/15 identified the resident had severely impaired cognition, had no behaviors, was totally dependent upon staff for bed mobility, locomotion on/off the unit, dressing, toilet use, personal hygiene and eating, required extensive staff assistance with transfers, and the activity of walking in the room/corridor did not occur. The resident was always incontinent of urine, weighed 137 pounds and had not experienced a weight loss. The MDS identified the facility assessed the resident was at risk for the development of pressure ulcers, had a pressure reducing device in his/her chair and on his/her bed, was not on a turning/repositioning program and did not have pressure ulcers.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/6/15 included the resident had impaired cognition, and had a

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diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion).

The resident's Activity of Daily Living CAA did not trigger.

The resident's care plan dated 4/3/15 included the resident required total assistance with night time care. Staff assisted the resident with undressing for bed and completed the resident's personal hygiene.

The resident's care plan did not include the resident's preference regarding the what time he/she would like to go to bed.

The resident's Preference Sheet dated 10/18/12 included the resident would like to go to bed between 8:30 P.M. to 9:00 P.M. There was not a current preference sheet in the resident's clinical record.

On 4/16/15 at 7:17 A.M. the resident sat in his/her wheelchair.

On 4/15/15 an interested party expressed concern regarding the resident's bed time. He/she stated staff placed the resident in bed around 6:30 P.M. and got the resident up between 7:00 A.M. to 7:30 A.M. which seemed like a long time for the resident to be in bed.

On 4/16/15 at 4:40 P.M. direct care staff OO stated staff placed the resident in bed around 7:00 P.M. Direct care staff PP present during the

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F 246	Continued From page 14 interview concurred with direct care staff OO. Direct care staff OO stated since the resident was unable to communicate what time he/she wanted to go to bed, staff placed the resident in bed when he/she looks tired. On 4/20/15 at 4:22 P.M. licensed nurse stated upon admission staff asked residents his/her bed time preference. He/she stated each quarter during care plan meetings staff discussed resident's bed time preference and staff updated the resident's preference form if needed. On 4/20/15 at 4:55 P.M. administrative nursing staff D stated staff completed a preference sheet upon admission and asked residents during care plan meeting his/her bed time preference. He/she stated the care plan included the resident's bed time preference. Administrative nursing staff D stated staff placed the resident in bed 30 minutes after dinner. The facility's undated Preference Policy and Procedure included staff asked the resident what time he/she wanted to go to bed and documented the information on the pocket sheet. If residents and family members disagreed with the decision he facility honored the request even if the resident was confused. The facility failed to ensure the resident's bed time preference was honored.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is	F 247		

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changed.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 52 residents. The sample included 21 residents. Based on interview and record review the facility failed to notify 2 resident's prior receiving a new roommate.(#4,38)

Findings included:

- On 4/14/2015 at 1:36 P.M., resident #4 revealed he/she had several roommate changes without notice being given prior to the roommate moving in.

A Social Services note dated 3/10/2015 2:49 P.M., revealed resident and family notified of new roommate. Both roommates introduce at this time. Will monitor as needed.

An interview on 4/15/15 at 2:48 p.m. social service staff E revealed he/she documented in the social service notes about roommate changes. Staff E revealed he/she did not notify a resident of a new roommate until the resident was in the facility and in the room.

The undated Resident Room Transfer/Roommate Change policy revealed the Social Service Designee would notify the resident that resided in the room currently that there will be a new roommate. If the new resident visits prior to the move in, they shall be introduced at that time. If not, they shall be introduced at the time of move in.

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F 247	Continued From page 16 The facility failed to notify resident #4 prior to him/her receiving a new roommate. - An interview conducted on 4/14/15 at 3:18 P.M. resident # 38 revealed he/she had a roommate change before Christmas and no one informed him/her prior to the change. Review of the clinical record for resident #38 from 12/1/15-4/15/15 lacked documentation regarding a roommate change. An interview on 4/15/15 at 2:48 p.m. social service staff E revealed he/she documented in the social service notes about roommate changes/notifications. Staff E confirmed he/she did not notify resident #38 of a new roommate. The undated Resident Room Transfer/Roommate Change policy revealed the Social Service Designee would notify the resident that resided in the room currently that there will be a new roommate. If the new resident visits prior to the move in, they shall be introduced at that time. If not, they shall be introduced at the time of move in. The facility failed to notify resident #38 prior to getting new roommate.	F 247		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250		

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services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 52 residents. The sample included 21 residents. Based upon observation, record review and interview the facility failed to provide medically related social services for 1 (#38) of 3 residents sampled for personal property.

Findings included:

Resident's #38 quarterly Minimum Data Set (MDS) dated 2/2/15 included the resident scored 15 (cognition intact) on the Brief Interview for Mental Status and wore corrective lens.

The resident's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 11/6/14 included the resident had a self care deficit and required staff assistance with his/her ADLs.

The resident's vision CAA did not trigger.

The resident's care plan dated 1/30/15 included the resident required staff assistance with ADLs.

The resident's care plan did not include the resident wore eyeglasses.

The resident's Inventory of Personal Effects dated 10/2014 included the resident had eyewear.

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On 4/14/15 at 3:13 P.M. the resident stated his/her prescription eyeglasses were missing. He/she stated he/she received the eyeglasses during the month of 12/2014 and the eyeglasses were misplaced/lost 2 days after he/she received the eyeglasses. He/she stated he/she informed social service staff E of the missing eyeglasses. The resident stated he/she did not have money to replace the eyeglasses and he/she was on Medicaid.

Observation at that time revealed the resident had on a pair of eyeglasses and the resident stated the eyeglasses were reading glasses. The resident stated his/her vision was affected without the prescription eyeglasses.

Review of the resident's clinical record on 4/15/15 at 2:00 P.M. lacked evidence to support the facility attempted to assist the resident in receiving a new pair of eyeglasses after his/her eyeglasses were lost/misplaced during the month of 12/2014.

On 4/15/15 at 2:24 P.M. social service staff E stated he/she was aware the resident's prescription eyeglasses were missing. He/she stated the resident only had the eyeglasses a couple of days before the glasses were misplaced/lost. Social service staff E stated the resident was on Medicaid and he/she did not think Medicaid would pay for another pair. He/she stated he/she had not inquired to see if the resident could another pair of prescription eyeglasses.

On 4/15/15 P.M. at 3:00 P.M. social service staff E stated he/she just spoke with the resident's

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F 250	Continued From page 19 Medicaid provider and the provider stated since the resident received a pair of glasses in 2014 he/she was eligible to receive another pair of glasses at no cost. On 4/16/15 P.M. at 8:15 A.M. the resident stated he/she had fought with the facility since January of 2015 regarding receiving a new pair of eyeglasses. The facility's undated Personal Property Policy and Procedure included the facility explained at the time of move in that if a resident was missing any item or property it needed to be reported to a department head immediately. Every effort was made to find and return the property. If the property was truly missing the facility followed the Abuse, Neglect and Exploitation Policy. If staff was responsible for the lost item it was replaced. The facility failed to assist the resident with obtaining a new pair of prescription glasses in a timely manner.	F 250		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

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by:
The facility had a census of 51 residents. The sample included 21 residents. Based upon observation, record review and interview the facility failed to implement effective interventions to prevent the development of pressure ulcers and to promote healing for 1 (#5) of 3 residents sampled for pressure ulcers.

Findings included:

- Resident #5's Significant Change Minimum Data Set (MDS) dated 4/1/15 identified the resident had severely impaired cognition, no behaviors, was totally dependent upon staff for bed mobility, locomotion on/off the unit, dressing, toilet use, personal hygiene and eating, required extensive staff assistance with transfers, and the activity of walking in the room/corridor did not occur. The resident was always incontinent of urine, weighed 137 pounds and had not experienced a weight loss. The MDS identified the facility assessed the resident was at risk for the development of pressure ulcers, had a pressure reducing device in his/her chair and on his/her bed, was not on a turning/repositioning program and did not have pressure ulcers.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/6/15 included the resident had impaired cognition, and had a diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion).

The resident's Activity of Daily Living CAA did not trigger.

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The resident's Urinary Incontinence CAA dated 4/6/15 documented the resident was incontinent of bowel and bladder. Staff checked the resident for incontinence every two to three hours. The resident did not ambulate and required assistance of 2 staff to transfer via a mechanical lift.

The resident's Nutritional Status CAA dated 4/6/15 included the resident required staff assistance with eating, received a mechanical diet and nutritional supplements. The CAA included the registered dietician (RD) assessed the resident's nutritional status and referred the reader to the RD's assessment dated 4/1/15.

The resident's Pressure Ulcer CAA dated 4/6/15 included the resident had the potential for an alteration in his/her skin integrity due to the resident did not ambulate, totally dependent upon staff for repositioning and was incontinent of bowel and bladder. The resident utilized a pressure relieving mattress on his/her bed and received a mechanical diet and nutritional supplements. The CAA included see the RD's assessment dated 4/1/15.

The resident's care plan dated 4/3/15 included staff checked and changed the resident every two to three hours. The resident received a mechanical soft diet and required staff assistance with eating. Staff repositioned the resident every 1 to 2 hours. The resident had a pressure relieving cushion in his/her wheelchair and a low air loss mattress on his/her bed and staff floated the resident's heels.

A nutritional assessment dated and signed by a

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RD on 4/1/15 included the resident had a left heel wound and staff initiated the facility's wound care protocol. The supplements and snacks the resident received and consumed continued to meet the resident's protein needs of 82 grams per day and calorie needs of 1326 kilocalorie per day.

The nutritional assessment did not identify the type of wound, the description or measurements of the wound.

A nurse's note (NN) dated 4/7/2015 and timed 11:26 A.M. documented on 4/6/15 staff observed the resident had an area of eschar (dead tissue) to his/her right heel (should be left heel) that measured 1.4 centimeters (cm) from by 2.0 cm. Staff applied skin prep (liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films) and a protective dressing and notified the resident's primary care physician and the wound company. The facility initiated the wound care protocol and placed heel boots on the resident. Staff repositioned the resident every two hours and floated the resident's heels when in bed and in the wheelchair. Staff would place an I-Heal mattress (pressure reducing device) as soon as it came in.

The resident's clinical record lacked any documentation other than the RD's assessment dated 4/1/15 regarding the unstageable pressure ulcer on the resident's left heel until the NN dated 4/7/15.

A wound company's note dated 4/7/15 documented the base of the resident's left heel

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was 100% (percent) black in color and measured 1.10 cm by 2.20 cm with a depth of 0.10 cm. Documentation included the wound was classified as other until the Doppler results were available.

A wound company's dated 4/14/15 included the resident had an unstageable pressure ulcer on his/her left heel that measured 1.30 cm by 1.90 by 0.10 cm.

A physician's order dated 4/7/15 included for the RD to assess the resident on his/her next visit to the facility, notify the wound company, pharmacy to review the resident's medications and to notify the resident's physician when the wound was healed.

A physician's order dated 4/8/15 included for the resident to receive Stress/Zinc (a dietary supplement) 1 tablet by mouth once a day for two weeks, and a multivitamin once a day.

A physician's order dated 4/14/15 included to clean the resident's left heel with a wound cleaner and to apply skin prep and for the resident to wear a Prevalon boot (device used to float the heels).

Review of the resident's weights from 10/22/14 to 4/9/15 revealed the resident's weight was stable at 138 pounds.

On 4/15/15 at 3:10 P.M. the resident laid in bed. Observation revealed the resident had a pressure reducing mattress in place and heel boots on. Observation did not reveal a low air loss mattress/alternating mattress on the resident's bed.

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On 4/16/15 at 7:10 A.M. the resident sat in his/her wheelchair with the heel boots in place.

On 4/16/15 at 7:20 A.M., 7:30 A.M., 7:40 A.M., 7:45 A.M. and 8:00 A.M. the resident sat in his/her wheelchair in the activity room.

On 4/16/15 at 8:15 A.M. the resident sat in his/her wheelchair at a dining room table and staff assisted the resident with the breakfast which consisted of sausage, eggs, hot cereal, juice and a health shake (a high calorie drink). The resident continued to sit in his/her wheelchair at the dining room table at 8:20 A.M., 8:25 A.M., 8:30 A.M. and 8:45 A.M. At 8:45 A.M. the resident had consumed all of the sausage, and eggs and over 75% of the hot cereal. The resident drank all of the health shake and juice.

On 4/16/15 at 8:55 A.M. staff wheeled the resident to the activity room. The resident continued to sit in his/her wheelchair in the activity room at 9:00 A.M., 9:05 A.M., 9:10 A.M., and 9:16 A.M.

On 4/16/15 at 9:24 A.M. direct care V and W lifted the resident from the wheelchair via the sit and stand lift, changed the resident's incontinent brief, placed the resident back in the wheelchair and placed a pillow under the resident's right buttock. Observation revealed the resident was incontinent of urine. Direct care staff W stated when the resident was on hospice the resident had a low air loss mattress but when the resident was discharged from hospice the resident received a new bed with a different mattress. Direct care staff V and W stated the resident had recently received the heel boots and prior to that the resident used the donut type device which

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was placed around the resident's ankle and staff floated the resident's heels. Direct care staff V stated staff placed the resident in the wheelchair a little after 7:00 A.M. that morning. Direct care staff V stated staff toileted and repositioned the resident every 2 hours.

On 4/20/15 at 2:30 P.M. observation revealed the resident had an unstageable pressure ulcer on his/her left heel that measured approximately 2.0 cm by 2.0 cm.

On 4/16/15 at 4:40 P.M. direct care staff PP stated prior to the use of the heel boots, the resident utilized ring/donut type devices and staff floated the resident's heels.

On 4/16/15 at 3:00 P.M. administrative nursing staff D stated he/she was aware ring and donut type devices should not be used on resident's bottoms but was not aware they should not be used to float heels.

On 4/20/15 at approximately 10:45 A.M. dietary consultant EE stated he/she assessed the resident's nutritional status on 4/1/15 and the resident had the left heel wound on that date and the resident's nutritional needs were met. He/she stated the facility did not document anything regarding wounds until the wound company assessed residents' wounds.

On 4/20/15 at 11:01 A.M. the surveyor contacted the manufacturer of the foot elevator. A representative stated he/she would have a product manager to contact the surveyor via telephone. At the time of this writing the manufacturer has not returned the surveyor's telephone call.

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F 314	Continued From page 26 On 4/20/15 at 11:50 A.M. nursing administrative staff D stated he/she was not aware the resident had the pressure ulcer on his/her left heel until 4/6/15 and it was his/her understanding that was the date staff observed the wound. He/she stated the wound care staff assessed the resident's left heel on 4/7/15. Administrative nursing staff D stated when staff first observe a wound/pressure ulcer, licensed nurses documented the location, whether it is a full thickness or partial thickness but do not measure or stage the pressure ulcers. He/she stated the wound company measured and staged pressure ulcers. Nursing administrative staff D stated prior to the development of the unstageable pressure ulcer staff floated the resident's heels. Administrative staff D stated he/she did not know whether staff placed the heel elevators on the resident prior to the implementation of the heel boot. On 4/20/15 at 4:16 P.M. licensed nurse M stated at one point the resident utilized the foam ring devices. He/she stated staff repositioned the resident every 1 to 2 hours which meant the resident should not sit in the wheelchair over 2 hours. He/she stated the unstageable pressure ulcer on the resident's left heel was facility acquired. He/she stated the resident wore the heel boot since the development of the left heel pressure ulcer. According to literature the foot elevator is a spiral-cut foam ring that helps skin on the foot and ankle heal by raising the foot completely off the bed. Use a pillow under the user's knee to prevent hyperextension when the foot elevator was in use.	F 314		

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According to The National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide 2014 do not use cutout, ring or donut type device to elevate heels. The edges of these devices create areas of high pressure that may damage tissue.

The facility's undated Wound Care Protocol included if a resident had a Stage 2 or greater wound: if the resident was not already receiving a Multivitamin, start the resident on a Multivitamin daily for 2 weeks then discontinue, start the resident on a Stress tab with zinc for two weeks, then discontinue, start the resident on 30 cubic centimeters (cc) of Prostat (supplement used to increase protein) twice a day with juice, the RD to see the resident on the next visit, obtain a physician's order for the wound company to evaluate and treat the wound. The protocol did not include licensed nursing staff assessing, measuring or documenting on the pressure ulcer.

The facility failed to treat, measure and document the appearance of the pressure ulcer for a duration of at least 5 days after the RD documented the resident had a wound on his/her left heel for this severely cognitively impaired resident who developed an unstageable pressure ulcer on his/her left heel. The facility also failed to ensure the foot elevator was the appropriate device to elevate the resident's heel prior to the development of the pressure ulcer.

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ATCHISON SENIOR VILLAGE	1419 N 6TH ST ATCHISON, KS 66002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28	F 314		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility identified a census of 52 residents. The sample included 21 residents. Based on observation, resident interview, and staff interview the facility failed to provide sufficient nursing staff to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings included:	F 353		

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- Observation on 4/16/15 at 9:05 A.M. a call light on the 200 hall was activated and staff did not respond to it until 9:16 A.M. A duration of 11 minutes.

Observation on 4/20/15 at 12:29 P.M. a call light on the 100 hall was activated and staff did not respond to it until 12:36 P.M. A duration of 7 minutes.

On 4/14/15 at 9:52 A.M. resident #36 reported he/she had to wait to be toileted due to staff stating they were busy.

On 4/14/15 at 1:19 P.M. resident #4 reported the call light wait times were extended throughout the day.

On 4/14/15 at 1:30 P.M. resident #46 reported a few weeks ago he/she had to wait on staff for 20 minutes to go to the bathroom.

On 4/14/15 at 1:55 P.M. resident #42 reported call light wait times were long around staff shift change times.

On 4/14/15 at 3:16 P.M. resident #38 reported he/she waited over 20 minutes for staff assistance to use the bathroom. He/she stated the facility was short staffed on all shifts.

Interview on 4/20/15 at 1:34 P.M. with licensed nursing staff M revealed it was difficult to meet the needs of the residents in a timely manner due to being short staffed. He/she stated at times staff did not get their planned days off and experienced burn out due to being short staffed.

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F 353	Continued From page 30 Interview on 4/20/15 at 2:06 P.M. with direct care staff O revealed at times the residents had to wait "longer than they should" due to not having enough staff. Interview on 4/20/15 at 2:13 P.M. with direct care staff V revealed recently the facility did not have enough staff which made it difficult to meet the needs of the residents in a timely manner. Interview on 4/20/15 at 2:16 P.M. with direct care staff U revealed for the last couple months staffing was short and sometimes only had 1 aide for the hall. He/she stated that made it difficult to meet the needs of the residents and answer call lights in a timely manner. The undated policy provided by the facility regarding staffing revealed staffing was assigned/scheduled based on resident need. Consideration for assignments and scheduling was the duration of call lights, frequency of call lights, and the acuity of the assigned neighborhood. The facility failed to provide sufficient nursing staff to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 52 residents. The facility had one main kitchen that served 1 dining room. Based on observation and interview, the facility dietary staff failed to maintain hair with a hair net for one of four days onsite of the survey, and failed to serve food in a sanitary manner for one of four days onsite of survey.

Findings included:

- Observation on 4/15/15 at 10:11 A.M. revealed activities volunteer staff MM cooked and prepared to serve chili to residents without wearing a hair net. His/her hair was loose and hanging down.

An interview on 4/15/15 at 10:16 A.M. activities volunteer staff MM stated he/she was supposed to wear a hair net but there were none available in the activities kitchen.

An interview on 4/16/15 at 2:22 P.M. kitchen supervisor staff DD confirmed staff should wear hair nets while handling food.

Observation on 4/16/15 at 11:34 A.M. revealed dietary staff FF served food to residents from the main kitchen. Staff touched resident menu's, dragged his/her gloved hands across the kitchen counter and used hands to place bread on plates for 18 residents.

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F 371	Continued From page 32 An interview on 4/16/15 at 1:12 P.M. with kitchen supervisor staff DD stated staff could use their hands to place bread on plates as long as they had not touch anything else prior or left the serving line. He/she confirmed staff should not have touched the bread with soiled gloved hands. An interview on 4/20/15 2:30 P.M. administrative nursing staff D stated he/she expected staff to wear hair nets and to wash hands if hands were soiled. The undated Food Handling policy revealed all staff should wear hair nets or caps to cover their hair while in the kitchen. All staff who handled ready to eat items would use single serve gloves or utensils. The facility failed to serve and prepare food in a sanitary manner.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility identified a census 52 residents. The sample included 21 residents. Based on observation, interview and record review, the facility failed to help prevent the development and transmission of disease and infection when linens were transferred uncovered.

- Observation on 04/14/15 at 12:24 P.M. revealed an uncovered clean laundry cart with folded clothes in hall 100 and 300.

Observation on 04/20/2015 at 08:10 A.M. soiled laundry was observed on the floor in the 100 hallway.

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F 441	Continued From page 34 Observation on 04/20/2015 at 11:39 A.M. housekeeping staff X distributed clothes to residents from an uncovered laundry cart on the 200 hallway. Observation on 04/20/2015 at 12:18 P.M. housekeeping staff X pushed an uncovered clothes rack, out of the laundry area and down the administrative hallway. An interview on 04/20/2015 at 2:24 P.M. administrative nurse D stated linens and clothes racks are to be covered when leaving the laundry room for distribution to residents. The undated facility Laundry Standards policy revealed " All laundry shall be delivered on a covered cart to ensure infection control". The facility failed to properly transport linens to minimize contamination.	F 441		
F 520 SS=F	. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 52 residents. Based on record review and interview the facility failed to maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff.

Findings included:

- The facility was unable to provide evidence of who attended the facility quality assessment and assurance (QAA) meetings.

Interview on 4/20/15 at 3:58 P.M. with administrative staff A revealed the facility did not

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keep record of who attended the QAA meetings. He/she stated the director of nursing and the medical director always attended but the other staff fluctuated depending on the topics being discussed.

The facility's undated Quality Assurance Committe policy revealed the committe shall consist of the Medical Director, Pharmacist, Administrator, DON (Director of Nursing), MDS (Minimum Data Set Cooridnator) and at least one other staff.

The facility failed to maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff.